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EXECUTIVE SUMMARY

PHYSICIAN WORKLOAD
CODEINES AND CODING

Adam Powell, Sergei Savin and Nicos Savva,'Physician workload and hospital reimbursement: Overworked servers generate lower income', Working Paper, August, 2011.

When it comes to physicians, everybody agrees that the time actually spent with patients is their most important job. As a result, some have suggested that one way to keep the focus on patients in the face of increased workloads is to reduce the time spent on paperwork. In fact, one study found that the level of paperwork-related stress today is so great that two-thirds of physicians would be willing to give up ten per cent of their income for a substantial reduction in paperwork.

But, even if it could be done, shedding all paperwork, such as writing detailed discharge summaries, is not a good idea. First, empirical studies show that the quality of physicians' discharge summaries is critical to adequate post-discharge follow-up. Second, because the discharge note is the primary input into the billing process, when a physician in a rush does not correctly provide the data needed to categorise the kind of care given, it can have negative impact for hospital reimbursement.

In order to determine the actual impact of physician workload on reimbursement rates in hospitals, Nicos Savva, Assistant Professor of Management Science and Operations at London Business School, along with Adam Powell and Sergei Savin of the Wharton School at the University of Pennsylvania, examined data from the trauma department of a major urban hospital in the United States. They find that patients discharged under high workload conditions were more likely to be coded as low severity for reimbursement purposes. This phenomenon, known as undercoding, can be very costly.

Patients coded as high-severity generate, on average, an extra 47.8 per cent reimbursement payment to the hospital. Workload related undercoding was estimated to cost approximately 1.1 per cent of annual revenue to the trauma department. The reasons for the failure to code correctly proved to be tied primarily to the number of same-day discharges completed by the discharging physician: the more discharges, the less likely the physician was to provide the details necessary to ensure the high-severity assignment. The research also showed that the number of inpatients under a physician's care also has an impact on the probability that a discharged patient is correctly assigned as high-severity.

Coding errors are not due to bad people but system failures that need to be rectified. System interventions, such as the automation of certain clinical functions, complemented by training of clinical and non-clinical staff in quality management, should be part of the solution. Another significant part could be changes in operational procedures that would free physicians from their current paperwork burden, perhaps by placing independent personnel in charge of generating such reports. Unfortunately, the people who could take over such a role, such as nurses, are themselves overworked. The answer could lie in using the additional revenue from correct coding to hire such personnel. ◻

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